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Experiences of patients following limb amputation: An interpretative phenomenological study

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Abstract

Background: Limb amputation is a life-changing surgical event that disrupts identity, social roles, and emotional well-being. While nursing care plays a central role in supporting patients during early postoperative admission, little is known about how nursing practices shape patients' sense-making and adjustment during this critical period, particularly in low-resource settings. This study aimed to explore how adult patients who have undergone surgical limb amputation make sense of limb loss during early postoperative admission, with particular attention to psychosocial impacts, information and support needs, and processes of coping and adjustment.

Methods: An Interpretative Phenomenological Approach was used to explore the early postoperative experiences of fifteen adults following upper or lower limb amputation in a tertiary hospital in South-Eastern Nigeria. In-depth interviews were conducted during inpatient recovery and analysed idiographically to examine how participants made sense of limb loss and nursing care encounters.

Findings: Four interrelated themes were identified. Encountering bodily loss captured shock and bodily disorientation following surgery. Disrupted identity reflected threats to dignity and independence, often intensified through reliance on nursing care. Navigating information and support highlighted the central role of nurses' explanations, reassurance, and presence in containing distress, while gaps in nursing communication amplified uncertainty. Coping and early adjustment described how nurses mediated family involvement and supported culturally grounded coping, alongside patients' ambivalence about dependence.

Conclusions: Early postoperative limb loss is a critical period in which nursing care plays a decisive role in shaping meaning-making, emotional containment, and early adjustment. Findings highlight the importance of relational nursing practices, clear communication, and culturally responsive support during inpatient recovery. Strengthening nursing-led psychosocial care during this phase may improve patient experience and longer-term adjustment following amputation in resource-constrained health systems.

Keywords: Limb amputation; Early postoperative experience; Meaning making; Interpretative phenomenological approach; Psychosocial adjustment; Nigeria

1. Introduction

Limb amputation is a life-changing surgical event that combines acute biomedical disruption with longer-term challenges related to identity, participation, and social belonging [1]. Contemporary literature increasingly

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conceptualises adjustment after amputation as an active process of meaning-making rather than a linear psychological response to loss [2]. Early postoperative experiences are commonly marked by shock, grief, fear, and uncertainty, shaped by sudden bodily change and anticipation of an unfamiliar future [3]. Qualitative accounts describe how pain, immobility, and dependence on others intersect with concerns about dignity, masculinity or femininity, and perceived social value, particularly during hospital admission when permanence of limb loss is still being negotiated [1]. Communication with nurses during the early postoperative period is central to how patients interpret limb loss and negotiate emotional security [2]. Nurses are typically the most consistent point of contact during inpatient recovery, providing wound care, pain management, explanations, and emotional reassurance. Clear, compassionate nursing communication has been associated with psychological containment and trust, whereas limited or task-focused interactions may intensify uncertainty and distress [3]. Evidence from inpatient mental health research in Nigeria similarly shows that early institutional encounters, uncertainty, and perceived responsiveness of staff strongly shape patients' sense-making, emotional security, and engagement with care during periods of acute vulnerability [4,5].

Psychosocial adjustment following amputation is also shaped by broader social and relational contexts, including family roles, economic security, and anticipated stigma [6,7]. Global studies consistently report that concerns about employability, dependency, and altered family dynamics emerge very early in recovery, often while patients remain hospitalised [8]. Such concerns are intensified in low- and middle-income countries where social protection systems are limited, and financial consequences of disability are largely borne by individuals and families [4]. Nigerian studies, though relatively few, indicate that people living with limb loss frequently experience stigma, social withdrawal, and loss of self-worth, particularly where disability is culturally associated with weakness or misfortune [9]. Family support is often described as both essential and burdensome, with gratitude for care coexisting alongside anxiety about becoming a long-term liability [5,9]. Parallel findings from Nigerian inpatient psychiatric settings describe stigma as an embodied and relational experience, negotiated through interactions with staff, peers, and family members, and closely linked to resilience under constrained systemic conditions [6]. Despite these insights, Nigerian amputation literature has largely focused on post-discharge community life, leaving early in-hospital recognition and interpretation of psychosocial challenges underexplored [9].

Information provision and supportive care represent another critical dimension of early post-amputation experience. International evidence indicates that patients value timely, honest, and comprehensible information about wound healing, pain management, prosthetic options, and rehabilitation timelines, particularly during the immediate postoperative phase when uncertainty is high [1]. Gaps in information have been associated with fear, unrealistic expectations, and delayed engagement with rehabilitation services [2]. In many low-resource contexts, including Nigeria, access to structured rehabilitation services, prosthetic fitting, and specialist follow-up remains limited by cost, workforce shortages, and fragmented referral pathways [4]. Studies from sub-Saharan Africa describe how patients often leave hospital without clear plans for rehabilitation or assistive technology, relying instead on informal advice, faith-based coping, or community support [8]. Nigerian research echoes these concerns, with participants reporting poor communication about post-discharge care and limited opportunity to discuss emotional distress with health professionals [9]. Comparable findings from inpatient mental health studies highlight how task-focused care, organisational pressures, and limited psychosocial engagement can leave patients feeling unheard during critical periods of vulnerability, reinforcing the relevance of institutional practices for early adjustment [5,6].

A conceptualisation that foregrounds early postoperative adjustment as a situated and relational process is therefore warranted. Stress and coping perspectives suggest that individuals appraise limb loss in relation to perceived threat, available resources, and future expectations, with coping strategies shaped by personal beliefs, social support, and healthcare interaction [2]. Faith, family solidarity, and acceptance frequently emerge as key coping resources in African contexts, yet their role in early postoperative meaning-making remains insufficiently examined within hospital settings [7]. Patient-centred rehabilitation frameworks further emphasise alignment between clinical care and patients' values, preferences, and social realities, particularly at transition points such as discharge planning [4]. Nigerian literature offers limited qualitative insight into how adults undergoing amputation interpret limb loss while still in hospital, how they perceive the adequacy of information and support provided, and how these experiences shape early coping and adjustment. Addressing this gap informs the study aim and questions by centring patients' own accounts of limb loss, identifying psychosocial and relational challenges that matter most to them, and illuminating opportunities to strengthen supportive care during a critical phase of recovery.

Aim

To explore how adults who have undergone surgical limb amputation make sense of limb loss during the early postoperative period, with particular attention to perceived psychosocial impacts, information and support needs, and processes of coping and adjustment.

2. Methods

2.1. Research design

This study adopted a qualitative design grounded in Interpretative Phenomenological Approach (IPA). IPA draws on phenomenological and hermeneutic traditions and is concerned with exploring how individuals make sense of significant life experiences within their social and cultural worlds [10]. Central to IPA is recognition of a double interpretative process, whereby participants attempt to understand their own experiences and the researcher, in turn, engages in an interpretive analysis of these accounts, often described as double hermeneutics [11]. This approach is particularly well suited to examining experiences of bodily disruption, illness, and trauma, where meaning is actively constructed rather than passively received. The design was appropriate for exploring how adults understand and negotiate limb loss during the early postoperative period, a phase commonly characterised by vulnerability, uncertainty, and emotional intensity. The study was positioned within an interpretive framework that values idiographic depth, allowing for detailed examination of individual cases before identifying shared patterns of meaning across participants [12]. IPA was selected due to its suitability for under-explored contexts and its capacity to centre participants' voices while attending to the institutional, relational, and cultural conditions shaping experience.

2.2. Study setting

The study was conducted at a large government-funded tertiary hospital located in South-Eastern Nigeria. The hospital functions as a major referral centre for surgical and trauma care across several neighbouring states, serving urban, sub-urban, and rural populations. Surgical services include emergency and elective procedures, with limb amputations frequently performed for indications such as trauma, diabetic complications, infections, and vascular disease. Inpatient care is delivered through shared surgical wards, with limited access to specialist rehabilitation and psychological services during the acute postoperative phase, reflecting broader resource constraints within the health system. Care is provided by a multidisciplinary team comprising consultant surgeons, medical officers, nurses, physiotherapists, and support staff. Family members often play a central role in bedside care, consistent with cultural norms and compensating for staffing limitations. Referral pathways include emergency admissions, transfers from district hospitals, and outpatient surgical clinics. This setting was selected due to its strategic importance in delivering amputation care within the region and its relevance for exploring early postoperative experiences in a low-resource context, where institutional practices and informal support structures strongly shape patient experience.

2.3. Participants and recruitment

Participants were adults aged 18 years and above who had undergone surgical limb amputation and were receiving inpatient postoperative care at the time of recruitment. Purposive sampling was used to identify individuals with direct experience of recent limb loss who were able to reflect on their early postoperative experiences, consistent with idiographic sampling principles in IPA research [11]. Inclusion criteria required that participants: (1) had undergone a major upper or lower limb amputation during the current admission; (2) were clinically stable as determined by the surgical and nursing team; (3) demonstrated sufficient cognitive and communicative capacity to participate in an in-depth interview; and (4) were able to speak and understand English. English proficiency was required to ensure analytic consistency, as resources for professional interpretation were not available. Exclusion criteria included individuals experiencing acute postoperative complications requiring intensive care, those with significant cognitive impairment or altered consciousness, and those deemed too medically unstable or distressed to participate.

Clinical stability was assessed collaboratively with ward nurses and attending clinicians, drawing on pain control, wound status, level of consciousness, and ability to sustain coherent conversation. This collaborative assessment reflects routine nursing decision-making in determining patients' readiness for engagement beyond physical recovery, including emotional and communicative capacity. Potential participants were initially approached by a designated gatekeeper, usually a senior nurse, who introduced the study and assessed interest, a strategy recommended to reduce undue influence in clinical settings [13]. Interested individuals received a written participant information sheet, which was also explained verbally in plain language. Participants were given between 24 and 72 hours to consider participation and consult family members if desired, supporting informed and voluntary consent.

Recruitment and data collection occurred concurrently, with attention to depth and richness of accounts rather than numerical representation, consistent with IPA methodology [11]. Data saturation was monitored throughout the study. After approximately twelve interviews, recurring experiential patterns became evident, particularly around shock, uncertainty, information needs, and reliance on family support. Additional interviews were conducted to ensure analytic depth and confirm saturation, resulting in a final sample of fifteen participants. Demographic characteristics

(presented in the Result section), type and level of amputation, and indication for surgery were recorded to provide contextual detail and support interpretive analysis.

2.4. Data collection

Data collection took place between April and November 2024, allowing sufficient time to engage participants across different surgical indications and stages of early postoperative recovery while accommodating ward routines and clinical demands. All interviews were conducted by the first author, an experienced qualitative researcher with a clinical background in nursing and qualitative health research. Maintaining a consistent researcher-participant interface supported the development of rapport and trust, which is particularly important when exploring sensitive experiences related to bodily loss, vulnerability, and uncertainty during hospital admission.

Interviews were conducted in quiet, private spaces within the surgical wards, such as consultation rooms or screened bedside areas, to ensure confidentiality, privacy, and emotional comfort. These locations were selected to minimise interruptions while remaining accessible for participants who had limited mobility following surgery. Each interview lasted between 60 and 90 minutes. Prior to each interview, the study aims and procedures were explained in clear and culturally appropriate language, with time allowed for questions and clarification. A semi-structured interview guide was used to provide consistency while allowing flexibility for participants to shape the conversation in line with their own priorities, consistent with IPA principles [11]. Key areas explored included experiences of limb loss, perceptions of bodily change, emotional and social impacts of amputation, information and communication received from healthcare professionals, perceived support needs, and early coping and adjustment processes.

The interview guide was reviewed by a senior qualitative researcher and a clinician involved in surgical care to ensure clinical relevance and sensitivity. As data collection progressed, the guide was iteratively refined in response to emerging insights and participant feedback, consistent with interpretive and reflexive qualitative practice [13]. For example, additional prompts were introduced to explore experiences of staff communication, uncertainty about rehabilitation and prosthetic access, and the role of family members during hospital admission. These refinements were made to deepen understanding of issues that participants consistently identified as meaningful, reflecting a commitment to responsiveness and co-construction of meaning within the research process.

All interviews were transcribed verbatim by the research team. Transcripts were checked against audio recordings for accuracy and completeness before analysis. Identifying information was removed, and each participant was assigned a unique code to ensure anonymity. Audio files, transcripts, and field notes were stored securely on password-protected and encrypted devices in line with institutional data protection policies and ethical guidance for research involving potentially vulnerable participants. Reflexive field notes were maintained throughout data collection to capture contextual observations, researcher reflections, and preliminary analytic thoughts. A summary of the interview guide and example prompts is presented in Table 1. Prompts were used flexibly, with the interviewer following participants' narratives and probing sensitively where appropriate, in keeping with the depth-oriented and idiographic aims of interpretative phenomenological research.

Table 1 Interview guide

Primary question	**Associated prompts**
Can you describe your experience of being in hospital after losing a limb?	How did you feel when you realised the limb had been removed? What were your first thoughts during the days after surgery? How has staying in hospital shaped this experience for you?
How do you understand the changes to your body and what they mean for your life?	What does the limb loss mean to you personally? How has it affected how you see yourself? Have your thoughts about your future, work, or family changed since the surgery?
How have you been feeling emotionally since the amputation, and how are you managing these feelings?	What emotions or worries come up most often? How do you cope when these feelings become difficult? What helps you feel calmer or more hopeful?

	What role do faith, personal beliefs, or inner strength play?
What support have you received from health professionals during your hospital stay?	How would you describe your interactions with nurses, doctors, or other staff? What has been helpful or unhelpful? Were there times when you felt listened to or not listened to?
What information have you been given about your surgery and what happens next?	What explanations were given about your wound, pain, rehabilitation, or prosthetic options? How clear was this information? What questions do you still have? How did gaps in information affect you?
How have your relationships with family or others been affected during this time?	Who has been supporting you since the surgery? How has your role within your family changed? Do you have any worries about depending on others or becoming a burden?
Have you experienced any social or cultural challenges related to the amputation?	How do you think others will see or treat you because of the limb loss? Are there cultural beliefs or social attitudes that affect how you feel about your body or your future?
How has the hospital environment affected your recovery and well-being?	How do ward routines, facilities, or visiting arrangements support or challenge you? What aspects of the environment make things easier or harder for you?
What helps you cope and adjust during this early period after amputation?	What personal strengths, supports, or daily practices help you manage? Have you developed new ways of coping since the surgery?
What changes would you like to see in hospital care for people who lose a limb?	What types of support would make the biggest difference? What advice would you give to health professionals caring for someone who has just had an amputation?

2.5. Ethical considerations

Ethical approval for this study for this study was granted by the Research Ethics Committee of Alex-Ekwueme Federal University Teaching Hospital, Abakaliki, Ebonyi State, Nigeria, on 15 February 2022 (2022/045). All procedures were conducted in accordance with the Declaration of Helsinki and relevant national guidelines for health research involving human participants. Eligible participants received written and verbal information about the study, including its purpose, procedures, potential risks, and benefits. Written informed consent was obtained from all participants prior to data collection. Participants were informed of their right to decline participation or withdraw at any stage without any impact on their clinical care.

2.6. Data analysis

Data analysis followed a structured, yet flexible approach rooted in IPA, enabling an in-depth exploration of how participants made sense of limb loss and early postoperative life within the inpatient surgical setting. Analysis was iterative and interpretive, drawing on interview transcripts, field notes, and reflexive observations, with the aim of producing contextually grounded accounts of participants' meaning-making processes. Each transcript was read and re-read alongside the corresponding audio recording to allow close attention to language use, tone, pauses, and emotional expression, all of which are central to phenomenological interpretation [14]. Field notes recorded during and immediately after interviews were reviewed to supplement transcript data with contextual insights related to participants' physical condition, ward environment, and interpersonal dynamics.

Initial analysis involved inductive coding, with detailed notes made on each transcript to capture descriptive, linguistic, and conceptual elements of participants' accounts. Codes were grounded in participants' own words and phrases, such as expressions of shock, uncertainty, gratitude, fear of dependency, or reliance on faith, reflecting salient experiences and emotional responses during early recovery. These initial codes were then examined for connections and patterns within individual cases before being compared across cases, consistent with the idiographic commitment of IPA [15]. Emerging codes were clustered into preliminary categories that reflected both shared meanings and points of divergence. Through repeated movement between individual transcripts and the wider dataset, higher-order themes were developed that captured the underlying significance of participants' experiences. For example, codes relating to bodily change, disrupted identity, and future uncertainty were synthesised into broader themes concerning renegotiation of self, while codes related to information gaps, staff communication, and family involvement informed themes around navigating care and support within the hospital context.

Reflexive engagement was maintained throughout the analytic process. Interpretations were discussed within the research team to challenge assumptions, deepen analysis, and ensure that emerging themes remained grounded in the data rather than driven by preconceptions [14]. Themes were continually checked against original transcripts to preserve fidelity to participants' accounts. The final stage of analysis involved refining and naming themes and constructing an analytic narrative that integrated interpretative commentary with illustrative quotations. Quotations were selected to reflect emotional nuance, contextual depth, and variation in experience, allowing participants' voices to remain central while supporting analytic claims [16].

2.7. Ensuring rigour

Several strategies were employed to enhance the trustworthiness of the study, in line with established qualitative research standards [15]. Credibility was supported through sustained engagement with participants and an iterative analytic process that allowed emerging interpretations to be revisited and refined over time. Conducting interviews across different stages of early postoperative recovery enabled a deeper understanding of participants' evolving perspectives. Dependability was strengthened through systematic documentation of methodological and analytic decisions. A clear audit trail was maintained, including records of recruitment procedures, interview conduct, coding development, theme refinement, and reflexive notes, allowing transparency in how findings were generated [13].

Transferability was addressed through the provision of thick description of the study setting, participant characteristics, and sociocultural context. Such detail enables readers to assess the relevance of findings to other surgical or low-resource healthcare settings [17]. Participant quotations were embedded throughout the findings to preserve authenticity and support contextual interpretation of themes [12]. Confirmability was enhanced through reflexive journaling and peer debriefing. Reflexive notes captured the lead researcher's positionality, assumptions, and emotional responses during data collection and analysis, supporting awareness of how interpretation was shaped [16]. Regular peer discussions provided opportunities to critically examine analytic decisions and challenge potential bias. Authenticity was prioritised by centring participants' voices and attending to both convergence and divergence in accounts. The idiographic and iterative nature of the analysis supported nuanced interpretation while respecting the complexity and individuality of participants' meaning-making processes during early postoperative adjustment.

3. Findings

3.1. Participant characteristics

The study included fifteen adults who had undergone surgical limb amputation and were interviewed during the early postoperative inpatient period. Participants represented a range of ages, genders, and social circumstances, reflecting the diversity of individuals accessing surgical care in the region. Clinical characteristics varied across the sample, including type and level of amputation and underlying indications for surgery, allowing exploration of meaning-making across different patterns of bodily loss and anticipated recovery trajectories. Social characteristics such as marital status, employment situation, educational background, and religious affiliation were also varied, providing important contextual insight into participants' support structures and coping resources. A summary of participants' demographic, clinical, and social characteristics is presented in Table 2.

Table 2 Demographic characteristics of participants

Participant ID	Age range (years)	Type of amputation	Level of amputation	Indication for surgery	Time since surgery at interview
P01	30-39	Lower limb	Below knee	Road traffic injury	7-14 days
P02	40-49	Lower limb	Above knee	Diabetic complications	2-3 weeks
P03	20-29	Upper limb	Below elbow	Industrial injury	≤7 days
P04	60-69	Lower limb	Below knee	Diabetic foot infection	3-4 weeks
P05	30-39	Lower limb	Below knee	Severe infection	1-2 weeks
P06	50-59	Lower limb	Above knee	Vascular disease	2-3 weeks
P07	30-39	Lower limb	Below knee	Road traffic injury	7-14 days
P08	40-49	Lower limb	Below knee	Diabetic complications	3-4 weeks
P09	20-29	Upper limb	Above elbow	Traumatic injury	7-14 days
P10	50-59	Lower limb	Below knee	Diabetic foot ulcer	2-3 weeks
P11	40-49	Lower limb	Below knee	Infection	7-14 days
P12	30-39	Lower limb	Above knee	Road traffic injury	7–14 days
P13	40-49	Lower limb	Below knee	Vascular disease	3-4 weeks
P14	20-29	Upper limb	Below elbow	Traumatic injury	≤7 days
P15	60-69	Lower limb	Above knee	Diabetic complications	≥4 weeks

Note: Age is presented in ranges and sex identifiers have been removed to minimise the risk of deductive disclosure and protect participant anonymity.

3.2. Overview of findings

Analysis identified four overarching themes that capture how adults made sense of limb loss during the early postoperative period. Findings show early adjustment as a process that unfolds over time, shaped by bodily experience, identity negotiation, interactions with healthcare staff, and the use of personal and relational coping resources. Table 3 summarises the themes, subthemes, and illustrative quotations. *Encountering bodily loss* reflects participants' initial experiences of amputation as a sudden disruption to bodily continuity, followed by gradual recognition of permanence. *Disrupted identity* highlights how loss of independence and anticipated social judgement challenged participants' sense of self and dignity. *Navigating information and support* demonstrates the central role of communication in shaping emotional security, with clear explanations offering reassurance and uncertainty intensifying distress. *Coping and early adjustment* captures how faith and family relationships supported emotional stability while also generating ambivalence around dependence.

Table 3 Themes, subthemes and illustrative quotes

Themes	Subthemes	Illustrative quotes
Encountering bodily loss	Shock and bodily disorientation	"When I woke up, I tried to move my leg like I always did. I was sure it was still there. When nothing happened, my mind just went quiet. It felt like my body and my brain were no longer working together." (P07)
	Recognising permanence	"After some days, it entered my mind that this leg is not coming back. That was when fear came. I started thinking about work, walking outside, and how people would look at me." (P12)
Disrupted identity	Loss of independence and dignity	"I used to be the one providing for my family. Now someone must help me bathe and move. It makes me feel small inside, like I no longer recognise myself." (P03)
	Anticipated social judgement	"I haven't even gone home yet, but I already feel ashamed. In my community, disability means weakness, and I keep imagining the looks and the whispers." (P10)
Navigating information and support	Information as reassurance	"When the nurse explained my wound and how it would heal, I felt calmer. Knowing what to expect made me feel included, like I was part of my own recovery." (P05)
	Living with unanswered questions	"Doctors talk among themselves and leave. I hear words I don't understand, and my mind starts imagining the worst. Not knowing is more frightening than the pain." (P14)
Coping and early adjustment	Faith as meaning making	"I believe God allowed this for a reason. I don't understand it now, but praying makes me feel that my life is not finished, even without my leg." (P01)
	Family support and ambivalence	"My wife helps me with everything, and I'm grateful. But inside I feel bad watching her do it all. I worry that I'm becoming a burden to the people I love." (P09)

3.3. Encountering bodily loss

This theme explores how participants first encountered limb loss as a sudden and destabilising bodily event. Early interpretations were shaped by confusion and disbelief, followed by a gradual recognition of permanence. Participants' narratives reveal how meaning emerged through bodily awareness before becoming cognitively articulated.

3.3.1. Shock and bodily disorientation

Participants described waking after surgery with a profound sense of bodily dislocation. At this stage, limb loss was not immediately understood as loss, but as a confusing absence that contradicted bodily memory. Emotional responses were often muted, with participants describing numbness rather than distress. This disorientation constrained early engagement with care and limited participants' ability to ask questions or seek reassurance.

"When I woke up, I tried to move my leg the way I always did. I was very sure it was still there. When nothing happened, I thought maybe the drugs were confusing me. Even when the nurse showed me the bandage, my mind refused to accept it. I just lay there quiet, staring, feeling like my body and my brain were no longer working together" (P07, Male).

This account illustrates how bodily memory persisted despite physical absence, creating a gap between sensation and understanding. The absence of immediate emotional expression reflects a state of suspension, where meaning had not yet caught up with physical reality.

"I could feel pain, but I couldn't understand what had happened. I kept touching the place, expecting to feel something. I wasn't crying or angry. I was just blank. It felt like my body knew something had changed, but my mind was slow to accept it. Everything felt confused and heavy inside" (P03, Male).

Here, pain may have functioned as both a reminder of surgery and a barrier to interpretation. Participants described being overwhelmed by sensation, leaving little cognitive space to process loss.

"Nobody explained much at first. I just woke up and felt different. I didn't know what questions to ask. I was too confused to speak. My thoughts were scattered, and I felt like I was floating. It took time before I could even say to myself that something serious had happened" (P14, Female).

This highlights how limited early explanation intensified disorientation, leaving participants alone with bodily confusion.

3.3.2. Recognising permanence

Recognition that limb loss was permanent marked a turning point in participants' narratives. This shift often occurred days after surgery and brought with it fear, grief, and future-oriented anxiety. Meaning making moved from bodily awareness to existential reflection, as participants began to confront the long-term implications of loss.

"…at first, I was only thinking about surviving the pain and letting the wound heal. After some days, it entered my mind that this leg is not coming back. That was when fear came. I started thinking about how I will walk outside, how I will work again, how people will look at me. That realisation was worse than the surgery itself" (P12, Female).

This illustrates how fear emerged not from pain, but from imagining the future. The permanence of loss forced participants to reassess previously taken-for-granted life plans.

"The operation was painful, but knowing it was permanent was heavier. My mind started racing ahead. Everything I planned before felt cancelled. I kept asking myself, what happens now? Nobody could give me clear answers, and that made the fear grow stronger each day" (P10, Male).

Here, permanence may have been experienced as temporal disruption, with the future becoming uncertain and unstructured. Lack of guidance compounded distress.

"One morning I just woke up and it fully entered my mind that this is my life now. Nobody prepared me for that moment. I lay there thinking about tomorrow and next year, and it felt like I was standing at the edge of something I didn't understand" (P06, Male).

These accounts suggest that recognition of permanence as a critical moment of meaning-making, where participants shifted from bodily confusion to existential uncertainty.

3.4. Disrupted identity

This theme examines how limb loss unsettled participants' sense of self, dignity, and social value. Identity disruption was closely tied to cultural expectations around independence, productivity, and bodily completeness.

3.4.1. Loss of independence and dignity

Participants consistently linked limb loss to loss of independence. Reliance on others for basic care challenged deeply held understandings of self-worth and dignity. These experiences were intensified by loss of privacy within the ward environment.

"I used to be the one providing for my family. Now someone must help me bathe and move. It makes me feel small inside. I keep asking myself who I am now. People don't see the man I was before; they only see what I lost, and that hurts deeply" (P03, Male).

This may reflect how dependency disrupted participants' moral and social identities, particularly those grounded in responsibility and provision.

"Being cleaned by someone else is very hard. Even though the nurses are kind, I feel exposed. I feel like my dignity is being taken away little by little. It's not the pain that hurts most, it's losing control over my own body" (P11, Female).

Loss of bodily autonomy here is framed as loss of dignity, highlighting the emotional impact of intimate care.

"As a man, you are taught to stand on your own. Now I cannot even stand without help. It affects how I see myself. Even when people encourage me, inside I feel weak and ashamed." (P06, Male)

The narratives consider dignity is relational and embodied, shaped by cultural expectations and daily interactions.

3.4.2. Anticipated social judgement

Participants frequently anticipated stigma and altered social treatment following discharge. These fears were grounded in community attitudes toward disability and shaped emotional responses while still hospitalised.

"Back home, disability means weakness. People will pity you or avoid you. I haven't even gone home yet, but I already feel ashamed. I keep thinking about the looks and whispers, and it makes my chest tight with worry" (P10, Female).

Anticipation of stigma produced emotional distress even before any actual social encounter occurred.

"I have seen how people talk about others with disability. They don't say it directly, but you feel it. That is what I am preparing myself for. It makes me quiet and distant, even here in the hospital" (P14, Female).

Here, participants began withdrawing socially in anticipation of rejection, showing how stigma operates pre-emptively.

"Sometimes I imagine myself walking outside and people staring. That picture stays in my mind all the time. It makes me afraid of going back to normal life" (P08, Female).

These narratives show anticipated judgement as a powerful force shaping early adjustment and self-protection strategies.

3.5. Navigating information and support

This theme highlights nursing care as a relational and interpretive practice through which patients made sense of limb loss. Participants consistently described nurses as key sources of information, reassurance, and emotional containment during inpatient recovery, positioning nursing interactions as central to early adjustment.

3.5.1. Information as reassurance

Participants described clear, compassionate explanations as emotionally containing and relationally affirming. Information enabled participants to organise an otherwise overwhelming experience into something intelligible and temporally bounded. Importantly, reassurance did not stem from certainty alone, but from being acknowledged as someone worthy of explanation.

"When the nurse explained my wound and how it would heal, I felt calmer. Even though the pain was still there, knowing what to expect helped me breathe better. It made me feel included, like I was part of my own recovery and not just lying there waiting for things to happen" (P05, Female).

This account highlights how explanation restored a sense of agency and relational inclusion. Feeling "part of" recovery allowed participants to reposition themselves from passive recipients to recognised participants in care, supporting early sense-making.

"When doctors talk slowly and explain things in simple words, I feel respected. It helps me understand what is happening to my body, and that reduces my fear. Even if the situation is serious, at least my mind is not running wild" (P01, Male).

Here, information is explicitly linked to respect and emotional regulation. Understanding limited catastrophic interpretation, suggesting that clarity functioned as both cognitive grounding and relational reassurance.

"Even when the news is not good, I prefer to know. Clear explanation helps me prepare my mind. When I know what is coming, I feel stronger inside and less afraid of surprises" (P09, Male).

This illustrates how information supported psychological preparedness rather than certainty. Knowing "what is coming" enabled anticipatory coping, reinforcing a sense of internal resilience during early adjustment.

Collectively, these accounts position information as a therapeutic and moral practice, through which patients felt recognised, steadied, and included within institutional care.

3.5.2. Living with unanswered questions

In contrast, silence, fragmented explanations, and inconsistent communication were experienced as forms of exclusion. Participants interpreted lack of information not simply as absence, but as withdrawal of recognition, which intensified fear and eroded trust in care. Unanswered questions left participants to construct meaning alone, often through imagined worst-case scenarios.

"Doctors talk among themselves and leave. I hear words I don't understand. My mind starts imagining the worst. I think maybe something bad is happening that they don't want to tell me, and that makes me very anxious" (P14, Female).

This account illustrates how institutional silence created space for catastrophic interpretation. Without explanatory access, participants filled gaps with fear, showing how silence actively shaped distress.

"Nobody can tell me clearly about artificial limbs or therapy. I keep asking, but there are no answers. That not knowing makes me afraid because I don't know if my life can still move forward" (P11, Female).

Here, uncertainty obstructed future orientation. Lack of information about rehabilitation undermined participants' ability to imagine continuity, suspending hope rather than merely delaying it.

"Sometimes the silence is worse than bad news. Not knowing what comes next keeps my mind restless, especially at night when there is nothing else to distract me" (P12, Male).

This highlights how uncertainty extended beyond clinical encounters into emotional life, shaping rumination during quiet moments. These narratives show how absence of information destabilised emotional containment and delayed early psychological adjustment.

3.6. Coping and early adjustment

This theme explores how participants actively mobilised personal and relational resources to cope with limb loss during hospital admission. Coping was dynamic rather than fixed, evolving as participants moved from shock toward reflection. Faith and family emerged as central resources, yet both carried emotional complexity that shaped adjustment in ambivalent ways.

3.6.1. Faith as meaning making

Faith played a central role in how participants interpreted limb loss and sustained emotional stability. Spiritual beliefs provided a framework through which loss could be contained, even when it could not yet be resolved. Faith often functioned less as explanation and more as a means of holding uncertainty without being overwhelmed by it.

"I believe God allowed this for a reason. I don't understand it now, but praying gives me strength. When I pray, I feel my life is not finished, even without my leg. That belief keeps me going" (P01, Male).

This account shows how faith supported existential continuity. Prayer did not remove uncertainty, but reframed it as survivable, allowing the participant to maintain coherence of self during disruption.

"Whenever my thoughts go too far and I start feeling afraid, I pray. It calms my heart and helps me feel steady again. Without prayer, I think I would break down" (P08, Female).

Here, faith functions as an emotional regulation strategy, helping to contain anxiety rather than resolve unanswered questions. Prayer provided emotional anchoring during moments of overwhelm.

"My faith reminds me that my value is not only in my body. Even now, I believe I still matter. That thought helps me face each day in this hospital" (P04, Male).

This illustrates how faith supported identity preservation, enabling participants to locate worth beyond physical integrity. Faith thus emerged as a stabilising resource that allowed uncertainty to be endured rather than eliminated.

3.6.2. Family support and ambivalence

Family presence was described as indispensable to coping, yet emotionally charged. Participants expressed deep gratitude alongside guilt and anxiety about long-term dependency. Unlike loss of independence discussed earlier, this subtheme centres on relational negotiation, moral responsibility, and concern for others' wellbeing.

"My wife is always here helping me. I am grateful, but inside I feel bad watching her do everything. I used to be the strong one. Now I worry that I am becoming a burden to her" (P09, Male).

This account shows how care simultaneously sustained recovery and threatened identity. Gratitude coexisted with moral discomfort, as participants measured themselves against prior relational roles.

"My family supports me and encourages me, but sometimes I feel ashamed needing them so much. I don't want them to suffer because of me" (P02, Female).

Here, dependency is framed as relational responsibility. Participants were not only receiving care, but actively monitoring its emotional and practical cost to others.

"I need my family now, but I keep thinking about the future. I don't want to depend on them forever. That thought worries me a lot" (P11, Female).

This reflects anticipatory anxiety about prolonged reliance. Family support enabled survival in the present, while simultaneously complicating imagined futures and autonomy.

4. Discussion

This study advances nursing knowledge by illuminating how early postoperative limb loss is negotiated through everyday nursing practices within surgical wards. Findings demonstrate that nurses play a central role in shaping patients' meaning-making, emotional containment, and early adjustment following amputation, particularly in contexts where specialist rehabilitation and psychological services are limited. Findings of this study align with contemporary phenomenological accounts of surgical trauma and bodily disruption [18,19]. Participants' descriptions of shock, disorientation, and delayed recognition of permanence resonate with international studies that frame amputation as a rupture of bodily continuity and narrative identity, particularly during hospital admission when meaning remains provisional and emotionally suspended. The findings advance this literature by demonstrating how bodily awareness precedes cognitive interpretation, reinforcing phenomenological arguments that early adjustment is grounded in pre-reflective experience rather than conscious appraisal alone [20].

Disrupted identity emerged as a central concern, with loss of independence and anticipated stigma shaping early adjustment. Comparable studies from Europe and North America describe threats to masculinity, productivity, and self-worth following amputation, particularly among working-age adults [21,22]. Evidence from African contexts remains limited, though existing work highlights stigma and social withdrawal as persistent challenges for people living with physical disability [23, 24]. This study contributes Nigerian-specific insight by showing how these concerns arise immediately after surgery, rather than emerging only during community reintegration, suggesting that identity threat is negotiated much earlier than commonly assumed.

Experiences of information and communication were found to play a decisive role in emotional containment and trust. International studies consistently demonstrates that clear, empathetic communication following major surgery supports psychological adjustment and engagement with rehabilitation [25]. Findings here extend this work by conceptualising information as a relational practice through which patients felt recognised and included, while silence was interpreted as institutional withdrawal. Similar patterns have been reported in African inpatient care, where task-focused routines and staffing constraints often limit meaningful dialogue with patients during acute care [26, 27]. These findings highlight how communication practices function as moral signals within constrained health systems.

Coping and early adjustment were strongly shaped by faith and family support. Faith-based meaning-making has been widely reported across African health research as a key resource during illness and disability, offering continuity, hope, and emotional regulation [28, 29]. Findings from this study deepen this understanding by showing how faith enabled participants to hold uncertainty without resolving it, supporting early emotional stability. Family support emerged as both sustaining and ambivalent, echoing global literature on caregiving burden and relational guilt following sudden disability [30]. Nigerian and sub-Saharan African contexts, where family involvement compensates for limited formal

rehabilitation services, appear to intensify this ambivalence. Overall, these findings contribute a nuanced account of early postoperative adjustment that is locally grounded yet globally relevant.

4.1. Limitations

A few limitations should be considered when interpreting these findings. The study was conducted in a single tertiary hospital in South-Eastern Nigeria, which may limit transferability to other regions or healthcare settings with different organisational structures or cultural norms. Participant accounts reflect early postoperative experiences only, and meaning making may evolve substantially following discharge, rehabilitation, or prosthetic fitting, suggesting that longitudinal follow-up would offer additional insight. English-language interviews were required due to resource constraints, potentially excluding individuals less fluent in English and shaping the type of narratives elicited, a recognised challenge in qualitative health research within multilingual contexts.

Researcher interpretation is an inherent feature of IPA, and although reflexive strategies were employed, analytic interpretations remain shaped by the researcher's positionality and professional background [11]. The sample size was appropriate for IPA but does not aim for representativeness, and findings should be understood as depth-oriented rather than generalisable [13]. Despite these limitations, the study offers robust, contextually grounded insights into an under-explored phase of amputation care within a low-resource setting.

4.2. Implications for practice and policy

Findings point to the need for greater recognition of nursing-led psychosocial care during the immediate postoperative period following limb amputation. Surgical and nursing teams should be supported to integrate structured, empathetic communication into routine postoperative care, recognising information provision as a relational and therapeutic intervention rather than an optional addition. Simple practices such as repeated explanations, opportunities for questions, and acknowledgement of uncertainty may substantially improve emotional containment and trust during hospital admission.

Policy frameworks in Nigeria and similar settings should prioritise early psychosocial support within surgical pathways, particularly where access to rehabilitation and prosthetic services is limited. Investment in training for nurses and junior doctors on communication and emotional support could strengthen patient-centred care without requiring significant infrastructural change. Formal recognition of family caregivers within hospital policy may also reduce relational strain by clarifying roles, expectations, and support needs.

Integration of culturally responsive support, including respectful engagement with patients' faith and belief systems, may enhance early coping and adjustment. Collaboration with chaplaincy services or community faith leaders could offer low-cost psychosocial support where mental health services are scarce. At a broader level, findings support calls for national disability and rehabilitation policies that address the emotional and relational dimensions of limb loss alongside physical recovery, aligning Nigerian practice with global commitments to holistic, person-centred surgical care.

List of Abbreviations

Abbreviation	Full term
IPA	Interpretative Phenomenological Approach
WHO	World Health Organisation
LMICs	Low- and Middle-Income Countries
REC	Research Ethics Committee

5. Conclusion

This study provides an in-depth exploration of how adults in Nigeria make sense of limb loss during the early postoperative period, revealing amputation as an embodied, relational, and meaning-laden experience shaped by bodily disruption, identity threat, communication practices, and culturally grounded coping resources. Findings demonstrate that psychosocial challenges emerge immediately following surgery, challenging assumptions that adjustment begins only after discharge or rehabilitation. Attention to information and support during hospital admission emerged as central to emotional security and early adjustment, with clear communication fostering trust and silence amplifying

distress. Faith and family support functioned as critical coping resources, enabling participants to hold uncertainty while navigating ambivalence around dependency and responsibility. These insights contribute new empirical knowledge from a Nigerian context, addressing a significant gap in African amputation research and extending global understanding of early postoperative adjustment. This study foregrounds patients' accounts of nursing care during early postoperative recovery, positioning nursing practice as central to psychosocial adjustment following limb loss and highlighting inpatient nursing care as a critical site for early intervention.

Compliance with ethical standards

Acknowledgments

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Disclosure of conflict of interest

The researchers declare no conflicts of interest.

Statement of ethical approval

Ethical approval for this study for this study was granted by the Research Ethics Committee of Alex-Ekwueme Federal University Teaching Hospital, Abakaliki, Ebonyi State, Nigeria, on 15 February 2022 (2022/045). All procedures were conducted in accordance with the Declaration of Helsinki and relevant national guidelines for health research involving human participants.

Statement of informed consent

All participants received written and verbal information about the study, including its purpose, procedures, potential risks, and benefits. Written informed consent was obtained from all participants prior to data collection. Participants were informed of their right to decline participation or withdraw at any stage without any impact on their clinical care.

Availability of data and materials

All data supporting the findings of this study are available within the paper.

Authors' contributions

AN and JO contributed to the conceptualisation and methodological design of the study. AN, JO, UE, and DA were involved in data collection and investigation. AN, JO, and SU undertook data curation and formal analysis. JO led the interpretation of findings and supervised the study. AN and JO drafted the original manuscript, while UE, ON, NW, SU, and DA contributed to critical review and editing. JO coordinated project administration and ensured availability of resources. All authors read and approved the final version of the manuscript.

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